42 USCA s 1396r-4
42 U.S.C.A. § 1396r-4

UNITED STATES CODE ANNOTATED
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7--SOCIAL SECURITY
SUBCHAPTER XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Current through P.L. 106-170, approved 12-17-99

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that--

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1369a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to

disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if--

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period, and

the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of--

(A) the fraction (expressed as a percentage)--

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)--

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent

patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either--

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that--

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital--

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to

the requirement of subsection (a) of this section if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) of this section and such payment adjustments are made consistent with the last sentence of subsection (c) of this section.

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988--

(A) the requirements of subsections (b) and (c) of this section (other than the last sentence of subsection (c) of this section) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) of this section shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) of this section shall apply, and

(D) subsection (g) of this section shall apply.

(f) Limitation on Federal financial participation

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as "DSH") allotment for the State for the fiscal year, as specified in paragraphs (2) and (3).

(2) State DSH allotments for fiscal years 1998 through 2002

The DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

	DSH Allotment (in millions of dollars)				
State or District	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	32	32	32
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171

Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1.

(3) State DSH allotments for fiscal year 2003 and thereafter

(A) In general

The DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraph (B), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) Limitation

The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of--

(i) the DSH allotment for the previous year, or

(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(4) Definition of State

In this subsection, the term "State" means the 50 States and the District of Columbia.

(g) Limit on amount of payment to hospital

(1) Amount of adjustment subject to uncompensated costs

(A) In general

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) of this section with respect to a hospital if the payment adjustment exceeds

the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) Limit to public hospitals during transition period

With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) Modifications for private hospitals

With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) Additional amount during transition period for certain hospitals with high disproportionate share

(A) In general

In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) of this section if the payment adjustment does not exceed 200 percent of the costs

of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], subchapter V of this chapter, subchapter XVIII of this chapter, or from third party payors (not including the State plan under this subchapter) that are used for providing such services during the year.

(B) Hospitals with high disproportionate share defined

In subparagraph (A), a hospital is a "hospital with high disproportionate share" if--

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital--

(I) meets the requirement described in subsection (b)(1)(A) of this section, or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) "Applicable minimum amount" defined

In subparagraph (A), the "applicable minimum amount" for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

(h) Limitation on certain State DSH expenditures

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH payment adjustments

The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) Applicable percentage of 1995 total DSH payment allotment

The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) Applicable percentage

(A) In general

For purposes of paragraph (1), the applicable percentage with respect to--

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 percentage

The percentage determined under this subparagraph is the ratio (determined as a percentage) of--

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) State 1995 DSH spending amount

For purposes of subparagraph (B)(ii), the "State 1995 DSH spending amount", with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) of this section under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) Requirement for direct payment

(1) In general

No payment may be made under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment--

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) Exception for current arrangements

Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.".

December 10, 1997

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA). Section 4711 of BBA repeals Sections 1902(a)(13)(A), (B), and (C) of the Social Security Act (the Act), requires states to implement a public process when changes in payment rates or payment methodologies are proposed, and applies to payments for items and services furnished on or after October 1, 1997. (See Enclosure 1 for background on Section 4711.)

Section 4711 of BBA replaced the Boren requirements with a new Section 1902(a)(13)(A) of the Act, which requires states to (a) use a public process for determining rates, (b) publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates, and (c) give interested parties a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications. In the case of hospitals, such rates must take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

The intent of Section 4711 is to provide states with maximum possible flexibility, as well as to minimize HCFA's role in reviewing inpatient hospital and long-term care state plan amendments involving payment rate changes. HCFA would consider the state to be in compliance with this provision if it elected to use a general administrative process similar to the Federal Administrative Procedures Act that satisfies the requirements for a public process in developing and inviting comment in Section 4711. This will allow states the flexibility to follow current state public procedures. If a state's public process is not currently being applied to rate setting, or does not currently include a comment period, then the state would need to modify the process. (See Enclosure 2 for public process options.)

The repeal of the Boren amendment cannot be interpreted to be retroactively effective; the Boren amendment still applies to payment for items and services furnished before October 1, 1997. Thus, inpatient hospital and long-term care state plan amendments that are currently pending approval by HCFA, including those where Boren requirement questions are the only outstanding issues, need to have these issues resolved before the amendments can be approved. However, we recognize that the intent in repealing the Boren amendment was to reduce HCFA's role in the institutional payment rate setting process and to increase state latitude in this area. In light of the less restrictive requirements now in place, HCFA is committed to working with states to expedite the resolution of outstanding Boren issues in existing pending amendments.

States that are not proposing changes in their payment methods and standards, or changes in rates for items and services furnished on or after October 1, 1997, need not immediately implement a BBA public process. States need only publish proposed rates, methodologies, and justifications prior to the proposed effective date of any changes in payment rates or payment methodologies. In other words, states are not required to subject their existing rates to a public process to the extent that those existing rates were validly determined in accordance with legal standards in effect prior to October 1, 1997. In the event changes are already underway, states are to submit the preprint page (or comparable language inserted elsewhere in the hospital and long-term care payment sections of the plan) with the next proposed amendment. (See Enclosures 3 and 4 for preprint pages.) We envision a streamlined Federal review process due to the fact that state plan amendments previously submitted under the Boren requirements were subjected to a more rigorous statutory standard both in terms of Federal review of their substance and the review process itself.

Comments or questions regarding this letter may be directed to Marge Lee via e-mail at mlee1@hcfa.gov, or by phone at

410-786-4361. You may also submit them directly to your HCFA regional office contacts. We will all strive to provide you answers in a timely manner.

Sincerely,

Sally K. Richardson

Sally K. Richardson
Director
Center for Medicaid and State Operations

Enclosures

cc:
Jennifer Baxendell
National GovernorsÆ Association

Joy Wilson
National Conference of State Legislatures

Lee Partridge
American Public Welfare Association

All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

55 FR 10077-01
1990 WL 326009 (F.R.)
(Cite as: 55 FR 10077)

PROPOSED RULES

DEPARTMENT OF HEALTH AND HUMAN SERVICE

Health Care Financing Administration

42 CFR Parts 440 and 447

[BPD-459-P]

Medicaid Program; Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

Monday, March 19, 1990

AGENCY: Health Care Financing Administration (HCFA), HHA.

ACTION: Proposed rule.

SUMMARY: The chief purpose of these rules is to set forth the requirements and options for Medicaid payments to hospitals that serve a disproportionate number of low-income patients with special needs.

The changes in the Medicaid rules are necessary to reflect specific requirements enacted in 1987 and designated as section 1923 of the Social Security Act in 1988. The intent of section 1923 of the Act is to ensure that, in establishing Medicaid payment rates, States take into account the special needs of these hospitals.

* * * *

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Questions Raised by States

During the time the disproportionate share provisions have been in effect, several questions have been raised by States, as discussed below.

* * * *

B. Treatment of hospitals that provide Medicaid services to recipients living in States other than the State where the hospital is located.

Some States have asked whether patient days furnished to out-of-State patients would be counted in determining the Medicaid utilization rate.

Section 1923(b)(2) of the Act bases the Medicaid utilization rate on a formula that includes patient days furnished to patients eligible for Medicaid. Section 411(k)(6)(A)(iv) of the MCCA amended section 1923(b)(2) of the Act, by changing "eligible under the State plan" to "eligible under a State plan" (underscoring supplied). This amendment makes clear that the State must consider the total number of patient days attributable to Medicaid recipients regardless of which State would be responsible for payment for the services. This is to ensure that each hospital that meets the Medicaid utilization test or the low-income ratio requirement is accorded disproportionate share status regardless of the origin of those patients.